MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address Orthofix, Inc. 1720 Bray Central Dr. McKinney, TX 75069	MDR Tracking No.: M4-04-1298-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Trinity Universal Insurance Co. Box 42	Date of Injury: Employer's Name: Insurance Carrier's No.: 11181040 9WG

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/23/03	**01/23/03**	**E0748NU**	**$1,468.44**	

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position summary; however, the rationale listed on the table of disputed services states, "TWCC-MAR for procedure code billed is 125% of Medicare allowable. Medicare allowable is $3,504.35 x 125% = $4,380.44."

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent did not respond to initial TWCC-60

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- HCPCS Code E0748-NU for date of service 01/23/03 denied as "510, C – Payment Determined; Negotiated Contract Price". The Medical Fee Guideline and Medicare Fee Schedule became effective 08/01/03; therefore, this date of service will be review according TWCC Rules and the 1996 Medical Fee Guideline if applicable. Per the 1996 Medical Fee Guideline, HCPCS Codes, this code does not have a MAR amount; therefore, per Rule 133.1(a)(8) the requestor has not met their burden of proof (i.e. redacted EOBs with same or similar services) to support additional reimbursement. Additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
1/23/2003	E0748-NU	$1,468.44	$0.00				
						Total Left Column:	$1,468.44
						Total Amount Due:	$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

	Marguerite Foster	01-28-05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____